Aetna Life Insurance Company

Mail Completed form to:
AETNA Inc.
151 Farmington Avenue
Hartford, CT 06156-3705

Argonne National Laboratory
Long Term Care Employee Enrollment Form

Instructions

1. *This form can be completed by a newly hired, active employee who is not functionally incapacitated and requesting coverage for the first time within 31 days of hire.*
2. *Be sure to provide complete information to avoid delays in processing. Make a copy of the completed form for your records, returning the original in the envelope provided.*

** Employees enrolling after 31 days of hire need to complete the 25-question Long Term Care Medical Questionnaire/Enrollment form.**

This Plan is not approved for Medicaid asset protection under the Illinois Long Term Care Partnership Program. However, this is an approved long term care plan under State Insurance Regulations. For more information about plans approved under the Illinois Long Term Care Partnership Program, call the Senior Help Line at the Department of Aging at 1-800-252-8966.

Part A: POLICYHOLDER/PREMIUM PAYMENT INFORMATION

Employer Name	Policyholder Number	Control Number
Argonne National Laboratory	**655073**	655073

Employee Only: Payroll Deduction (06) (Choose One):
- ☐ Illinois Payroll (50-001): Payroll Deduction (06) Monthly
- ☐ Idaho Payroll (50-002): Payroll Deduction (06) Monthly

Part B: PLAN OPTIONS/DAILY BENEFIT

Benefit Number: Actives **002**

Daily Benefit Amount (Select any amount from $50 to $276 in $1 dollar amounts) : _____

Part C: EMPLOYEE INFORMATION

Enrollee Name (Last, First, Middle Initial)	Social Security Number		Employee Number
	___ ___ ___ - ___ ___ - ___ ___ ___ ___		___ ___ ___ ___ ___
Street Address	**City**	**State**	**ZIP Code**
Daytime Phone Number	**Birthdate (Month/Date/Year)**	**Sex**	**Hire Date**
( )	/ /	M F	/ /

Do you need any human assistance or supervision of any kind to perform the following everyday living activities: eating, dressing, walking, bathing, getting into or out of a bed or chair, using the toilet, continence, or mobility?

Yes___ No___

I understand that if I answer "Yes" and Aetna determines that I am not able to solely perform any of the activities described above, I will not be eligible to enroll in this Long Term Care plan.

Part D: Certification/Authorization

Certification. I certify that the information provided on this form is complete and true to the best of my knowledge and belief. I agree that this document is my enrollment request for group Long Term Care Insurance. I understand that any misstatements or omissions will make any insurance based upon this enrollment form void at the option of Aetna. I agree to make the required contributions via payroll deduction in accordance with the group policy issued.

I understand that in order for my coverage to take effect, I must be actively at work on the coverage effective date.

_____ _____

Employee's Signature **Date Signed**

Part E: Lapse Notification

If, after your coverage takes effect, you stop paying premiums, you will receive notice that your coverage is about to lapse (terminate). We will be glad to send a copy of this notice to another person if you would like. That person will not be responsible for payment of the premium, and you will always receive your own copy of the notice. If you want a copy sent to another person, please give us that person's name and address:

_____

Name (First, Last)

_____

Street Address City State ZIP Code